Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 10, 2016

Ms. Rose Mary Mayhew, Manager
Bel Aire Center
35 Bel Aire Drive
Newport, VT 05855-4953

Dear Ms. Mayhew:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 25, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

Division of Licensing and Protection

FEB 26 2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0104	A. BUILDING: _____ B. WING _____	C 01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEL AIRE CENTER	35 BEL AIRE DRIVE NEWPORT, VT 05855

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite re-licensing survey was conducted on 1/25/16 by the Division of Licensing and Protection. The following regulatory deficiencies were identified.	R100		
R149 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.9.c (6) Maintain a current list of all treatments for each resident that shall include: the name, date treatment ordered, treatment and frequency prescribed and documentation to reflect that treatment was carried out; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the home failed to ensure that treatments were documented as being completed for 1 of 5 residents sampled (Resident #1). Findings include: Per observation on 1/25/16 at 10:30 AM, Resident # 1 had an oxygen concentrator in use in their room. The oxygen tubing piece that has the nasal cannula on it was unlabeled as to when it was last changed. Per interview with the medication tech staff who was working, the tubing is to be changed weekly for the nasal cannula part of the concentrator tubing. This med tech stated that it was to be changed every Wednesday and documented on the treatment sheet in the Medication Administration book. The medication tech confirmed that they had changed the tubing themselves two weeks ago on 1/13/16, and had forgotten to document this. The med tech could not confirm whether a different staff	R149	Bel-Aire Residential Care Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law. **R 149** Resident #1 oxygen tubing changed and dated 1/25/2016. TAR updated, staff reeducated regarding the required weekly documentation needed. Random audits will be conducted by the Administrator or designee x3 months. Oversight by the administrator R149 3/10/16 POC accepted Karen Campos RN	1/26/16

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rose Mary Mayhew | TITLE: Administrator | (X6) DATE: 2-23-16

STATEMENT OF DEFICIENCIES AND PLAN DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R149	Continued From page 1 person had changed the tubing on 1/20/16 as they also had not labeled the tubing with the date changed or documented this in the treatment section. Per review of the treatment sheet of Resident #1 for December 2015, the changing of the oxygen tubing was not documented as completed for the entire month of December 2015. Per interview on 1/25/16 at 2:35 PM, the Director of Nursing confirmed that the staff have not been documenting the tubing changes, and that the current tubing in use for Resident #1 was not labeled with the date it was changed.	R149	**R172** Insulin pens for residents #2 and #3 were replaced and labeled properly. Staff reeducation occurred 1/26. Random audits will be conducted by the Administrator or designee X 3 months, Oversight by the administrator.	1/26/16
R172 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.h All medicines and chemicals used in the home must be labeled in accordance with currently accepted professional standards of practice. Medication shall be used only for the resident identified on the pharmacy label. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the home failed to ensure that Insulins were properly labeled for 2 of 2 residents sampled (Resident #2, #3). Findings include: 1. Per observation of the medication cart on 1/25/16 at 1:55 PM, there were two insulin pens in use present in the cart. The first insulin pen was noted to have no name written on it. This Lantus Insulin pen was identified by the designated medication technician as belonging to Resident #2. The staff also confirmed that the pen was opened and in use, and unlabeled with	R172	R172 POC accepted 3/10/16 Karen Campos RN	

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R172	Continued From page 2 the resident's name and what date the pen was first put in use. 2. Per observation on 1/25/16 at 1:55 PM, the medication cart also contained a Lantus Insulin pen labeled with the name of Resident #3. This insulin pen did not have a date written on it to indicate when it had first been put in use. This was confirmed by the medication technician also at that time. Per interview on 1/25/16 at 2:05 PM, the Director of Nursing confirmed that the two insulin pens were unlabeled with either the name of the resident, and/or lacked an indication of the date they were opened.	R172		